Important Medical Information Form

Student Name: **Date of Birth:**

Parent/ Guardian Name(s):

Telephone: (Cell)_____ **(Home)** _____ **(Work)**_____

Telephone: (Cell)_____ **(Home)** _____ **(Work)**_____

Emergency Contact Information: (other than parent/guardian)

(1) _____ _____
Name Relationship to Student

_____ _____
Phone Number Other Contact Information

(2) _____ _____
Name Relationship to Student

_____ _____
Phone Number Other Contact Information

Primary Care Physician's Name and Contact Information (in case of an emergency):

Health Insurance Provider's Name, Policy #, and Contact Information (in case of emergency):

Insurance Provider Claim Instructions/Procedures (in case of emergency):

Student has the following health issues and/or allergies of which SPS should be aware:
Health Issues:

Allergies (food, medication, insects, plants, animals, etc.):

Student takes the following medications and/or prescriptions of which SPS should be aware:

List requirements/directions for administration of this medication:

If medication is taken on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Is there any factor that makes it advisable for your child to follow a limited program of physical activity, (i.e. asthma, recent surgery, heart condition, abnormal fear, etc.)?

If yes, specify the ways in which you wish his/her program limited:

Additional information of which SPS should be aware concerning student's health:

I authorize the release of the information given above to other school staff in order to coordinate services.

_____ _____
Student Signature, if at least 18 years of age Date

_____ _____
Parent/Guardian Signature, if student is under 18 years of age Date

* If necessary, attach doctor's letter to this form.
* If necessary, attach copies that document student's shots and immunizations to this form.